

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

07188

Reg. Dist. No. 100

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County..... Charles

City or town..... Rural : ALLENS FRESH

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Charles Bowling

4. Sex

M W Married

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

Mannie S. Bowling

7. Birth date of deceased (mo., da., yr.)

6. (c) If alive, give age..... years

July 12, 1867

8. AGE:

Years 81 Months 13 Days 13 If less than one day hrs. min.

9. Birthplace.....

(Town, county, and state)

Va.

10. Usual occupation.....

Farmer

11. Industry or business

Waglace Bowling

MOTHER FATHER

12. Name.....

St. Marys Co. Md.

13. Birthplace.....

Ellen Doleman

14. Maiden name.....

Va.

15. Birthplace.....

Mrs Annie Bowling

16. Informant.....

Faulkner

Address.....

17. Burial.....

Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Dentonsille M. S.

Location.....

Dentonsille, Md.

18. Funeral director.....

Hunt &amp; Ryon

Address.....

Meadow, Md.

19. Date rec'd by registrar.....

1948

Date signed.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Rural : Allens Fresh

(If outside city or town limits, write RURAL and give nearest town)

Street No. -

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

EST

20. DATE OF DEATH..... Sunday July 25 1948 at 11:37 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jun. 1948 to 25 July 1948

and that I last saw h. m. alive on

Immediate cause of death..... Uremia underlying

Cause Destruction of the kidney structures

because of increased pressure of the urine

Due to..... Enlarged Prostate

Duration..... 6 years.

Due to.....

Other conditions..... Semile, arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations..... none

Date of op.....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... no Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... Dr. Wooddy, M.D.

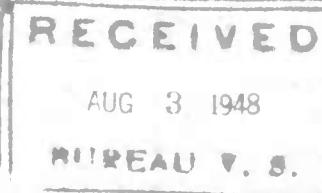
M. D. or other

Address..... La Plata, Md. Date signed..... 25 July 48

Char Bowling, Sr. M.D.  
Chas. T. T. M.D.  
Supply every item of information carefully; use correct age  
especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15N



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07189

## CERTIFICATE OF DEATH

91  
Reg. Dist. No. 100

1. PLACE OF DEATH: *Charles*  
 County: *Hughesville*

City or town: *Hughesville* (If outside city, town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: *Md.* County: *Charles*

City or town: *Hughesville* (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (a) FULL NAME

*Annie Briscoe*  
 4. Sex: *F* 5. Color or race: *Col* 6.(a) Single, married, widowed, or divorced: *Widowed*

6.(b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): *Sept. 7, 1870* 6.(c) If alive, give age: *years*

8. AGE: Years: *77* Months: *10* Days: *23* If less than one day: *hrs. min.*

9. Birthplace: *Bryantown, Md.* (Town, county, and state)

10. Usual occupation: *Housework*

11. Industry or business:

12. Name: *Frank Farmer* 13. Birthplace: *Chas. Co. Md.*

14. Maiden name: *Rosie Jackson* 15. Birthplace: *Prince George Co. Md.*

16. Informant: *Edith Briscoe* 17. Burial: *St. Mary's Cemetery* Date thereof: *8/2/48*

(Burial, cremation, or removal. Which?) *8/2/48* (month) (day) (year)

Location: *Bryantown, Md.*

18. Funeral director: *Hunt & Ryan* Address: *Wadsworth, Md.*

Address: *Aug 3, 1948* (Date rec'd by registrar)

19. Registrant: *John H. Giffen, M.D.* Address: *Hughesville* Date signed: *7/30/48*

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *July 30, 1948* at *3:40 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *April 1, 1948* to *July 30, 1948*

and that I last saw her alive on *July 30, 1948*

Immediate cause of death:

*GANGRENE, ARTERIO-SCLEROTIC, BOTH LEGS*

Due to: *GENERALIZED ARTERIO-SCLEROSIS*

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: *✓* Date of: *7/30/48*

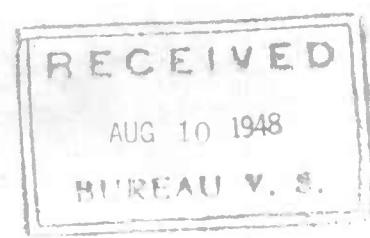
Where did injury occur? *Hughesville* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: *✓* Injured at work?

23. SIGNATURE: *John H. Giffen, M.D.* M. D. or other

Address: *Hughesville* Date signed: *7/30/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

07190

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County

Charles

City or town

En route to La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

En route

Hospital, institution, or street address where death occurred:

D.O.A. Physicians Memorial Hospital

How long in hospital or institution?

D.O.A.

## 3. (a) FULL NAME

Charles Walter Delp

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

## 8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age

years

Oct. 31, 1936

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

12. Name

Walter Charles Delp

13. Birthplace

Baltimore, Md.

14. Maiden name

Cora Mae Farrell

15. Birthplace

Newberg, Md.

16. Informant

Walter Charles Delp

Address

Waldorf, Md.

17. Burial

Date thereof

(month) (day) (year)

(Burial, cremation, or removal. Which?)

7/24/48

Cemetery or crematory

St. Pauls

Location

Waldorf, Md.

18. Funeral director

Hunt &amp; Ryan

Address

Waldorf, Md.

19. Date rec'd by registrar

7-23-48

18

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Md. Charles

City or town

Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 22, 1948, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that deceased

Jan. 22, 1948,

1948,

and that deceased died on

July 22,

1948

Immediate cause of death

Fracture of base of skull

Due to

Auto accident

Due to

Rode bicycle into moving auto

DURATION

15'

—

15'

—

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident Date of 7-22-48

Where did injury occur

Charles, Md.

(City or town) (State)

Injured at home, farm, industry, public place (where?) State highway # 301

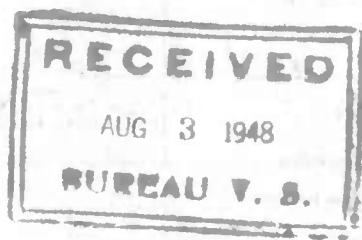
Means of injury Rode bike into auto Injured at work? No

Deputy Medical Examiner

23. SIGNATURE

John J. Mackay, M.D. M. D. or other

Address La Plata, Md. Date signed 7-22-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 96

07191

105100

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: *Charles*  
County: *Hughesville*

City or town: *Hughesville*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

3. (a) FULL NAME

4. Sex: *M* 5. Color or race: *W* 6. (a) Single, married, widowed, or divorced: *Married*

6. (b) Name of husband or wife: *Nellie E. Farrell*

7. Birth date of deceased (mo., day, yr.): *Sept. 17, 1883* 8. (c) If alive, give age: *90* years

8. AGE: *64* Year *9* Month *20* Day If less than one day *hrs.* *min.*

9. Birthplace: *Benedict, Md.* (Town, county, and state)

10. Usual occupation: *Restaurant operator*

11. Industry or business: *Richard Farrell*

12. Name: *Benedict, Md.*

13. Birthplace: *Benedict, Md.*

14. Maiden name: *Julia Welch*

15. Birthplace: *Benedict, Md.*

16. Informant: *Nellie E. Farrell*

Addressee: *Hughesville, Md.*

17. Burial: *St. Mary's* Date thereof: *7/19/48*  
(Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: *Briantown, Md.*

Location: *Henry & Ryan*

18. Funeral director: *Waldorf, Md.*

Addressee: *7-8*

19. (Date rec'd by registrar) *19.48* *M. L. Morris*

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants, give residence of mother)

State: *Md.* County: *Charles*

City or town: *Hughesville*  
(If outside city or town limits, write RURAL and give nearest town)

Street No.:  (If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *July 7* 19. *48* at *6:00 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *SEPTEMBER 30, 1947* to *JULY 7, 1948*

and that I last saw h. *1.74* alive on *JULY 7, 1948*

Immediate cause of death: *BRONCHO-PNEUMONIA*  
(*HYPOSTATIC TYPE*) DURATION *2 DAYS*

Due to: *PONTINE HEMORRHAGE* 7 months

Due to: *CEREBRAL ANEURYSM* UNKNOWN

Other conditions: (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide:  Date of

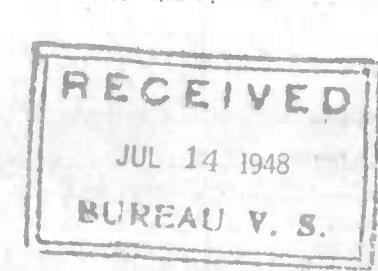
Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE: *John H. Griffin, M.D.* M. D. or other

Addressee: *Hughesville, Md.* Date signed *7/18/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07192

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County.....

Charles

La Plata

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Alice Cerelia Lee

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Cal.

Widowed

6. (b) Name of husband or wife.....

Harris Lee

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... years

July 28, 1872

8. AGE:

Years

Months

Days

If less than one day

76

2

hrs.

min.

9. Birthplace.....

Charles Co., Md.

(Town, county, and state)

10. Usual occupation.....

Hsiao

11. Industry or business

Hosiery Adams

MOTHER FATHER

12. Name.....

13. Birthplace.....

Chas. Co., Md.

14. Maiden name.....

Betty Adams?

15. Birthplace.....

Chas. Co., Md.

16. Informant.....

Berrie Lee

Address

La Plata

17. Burial

Burial Chapel

(Burial, cremation, or removal. Which?)

Date thereof. 8-3-48  
(month) (day) (year)

Cemetery or crematory.....

Burial Chapel

Location.....

La Plata, Md.

18. Funeral director.....

Hunt &amp; Ryan

Address

Waldorf, Md.

19. 8-2-48, 19.....

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Charles

City or town.....

La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 31

1948 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on July 31, 1948, to

and that I last saw him alive on July 31,

1948

Immediate cause of death.....

Chronic myocardial degeneration

Due to.....

Due to.....

Other conditions Atrial fibrillation

3-4 mads

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. \_\_\_\_\_

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

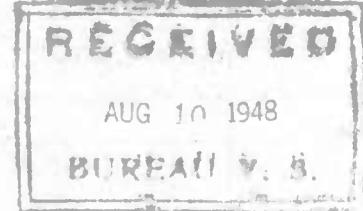
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE: \_\_\_\_\_ M. D. or other

Address: La Plata, Md. Date signed: 8-2-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07193

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH

County

Charles

City or town

La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lester Clifford Parson

4. Sex

M W

5. Color or race

6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Lillian J. Parson

## 7. Birth date of deceased (mo., day, yr.)

Sept. 10, 1907

6. (c) If alive, give age years

## 8. AGE:

Years Months Days

If less than one day

40 9 26

hrs.

min.

## 9. Birthplace

Newmanstown, Pa.

(Town, county, and state)

## 10. Usual occupation

Fireman

## 11. Industry or business

Steam Power, T. &amp; J. C. Patzer &amp; Co.

No.

## 12. Name

Lloyd H. Parson

Pa.

MOTHER FATHER

13. Birthplace

Emma Strickler

Pa.

MOTHER

14. Maiden name

Lillian J. Parson

Pa.

FATHER

15. Birthplace

Hermanville, Md.

Pa.

FATHER

16. Informant

Lillian J. Parson

Pa.

FATHER

Address

Hermanville, Md.

Pa.

FATHER

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Rehersburg Pa.

Location

Hunt &amp; Ryan

Funeral director

Maedorf, Md.

Address

Julia H. Parson

Registrar

VS A15 9-45-15N

17

Date rec'd by registrar

7/7

1948

Date signed

7/7/48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

St. Mary's

City or town

Hermanville

(If outside city or town limits, write RURAL and give nearest town)

Street No

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

7-6

1948 at

48

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-4 1948 to 7-6 1948

and that I last saw h. 7-4 alive on 7-4 1948

Immediate cause of death

Todesis

Paralytic Ileus

Due to

Dissection

Due to

following (7 days) post

abst. operation (Appendectomy)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Appendicitis

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hedden H. J.

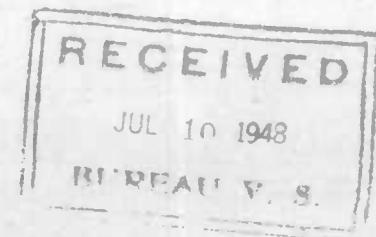
M. D. or other

Address

La Plata, Md.

Date signed

7/7/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a  
Reg. Dist. No. 07194

## CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County.....

Charles

City or town.....

Rural - Waldorf

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

About 10 days

Hospital, institution, or street address where death occurred:

Home

How long in hospital or institution?.....

## 3. (a) FULL NAME

Harriet Petersen

4. Sex:

Se

5. Color or race

Sl

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife.....

7. Birth date of  
deceased (mo., day, yr.)

Jan 15 - 18-77

6. (c) If alive, give age..... years

8. AGE:

71

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Chas Co

(Town, county, and state)

10. Usual occupation.....

Home nurse

11. Industry or business

12. Name.....

Harriet Petersen

13. Birthplace

Chas Co MD

14. Maiden name.....

Anna Bleses

15. Birthplace

Chas Co MD

16. Informant.....

Viola Petersen daughter

Waldorf MD

Address

Burial

Date thereof..... 7-6-48

17. (Burial, cremation, or removal. Which?)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

St Peters

Location.....

Waldorf MD

18. Funeral director.....

Dwight &amp; Lyons

Address

Waldorf MD

19. Date rec'd by registrar

July 6 1948 M. L. Munroe

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 3 1948 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

July 2 1948 to July 3 1948

and that I last saw him alive on July 3 1948

Immediate cause of death.....

Adagel

Due to.....

Cerebral Hemorrhage

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

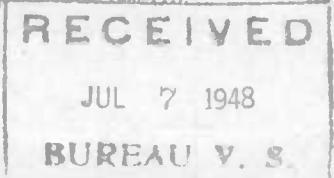
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Edwin L. Lane M.D. or other

Address..... Waldorf MD Date signed 7-6-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. ~~incorrect age~~  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07195  
105

Reg. Dist. No. ....

1. PLACE OF DEATH: Charles  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
Hospit, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MD County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
(If rural, give LOCATION)

## 3. (a) FULL NAME

Heribert Rudolph Ristori | 389 |  
4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Dead

7. Birth date of deceased (mo., day, yr.) March 1 1869 8. (c) If alive, give age ..... years

8. AGE: 79 Years 05 Months 00 Days 00 It less than one day  
..... hrs. ..... min.

9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation Butcher

11. Industry or business Muskrat

12. Name Muskrat  
13. Birthplace Probably Germany

14. Maiden name Muskrat  
15. Birthplace Probably Germany

16. Informant Charles M. Chaney  
4317 Clagett Parkway Hyattsville  
Address

17. Burial Burial Date thereof 7-16-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln and md

Location Linett & Ryan

18. Funeral director Waddell and MD

Address McGillards

19. 7-16 19. 48 McGillards  
(Date rec'd by registrar) Registrar

2. (a) If veteran, name war SP | 3. (b) Social Security Number 389

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 7-11 1948 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19. to ..... 19.  
and that I last saw h. .... alive on ..... 19.

Immediate cause of death

Drowning | April | 7-11-48 |  
DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations Coroners Case Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... ? Date of ....

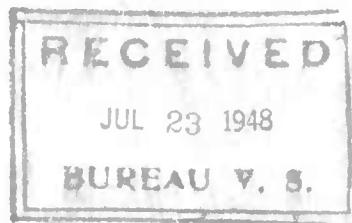
Where did injury occur? Potomac River (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Potomac River

Place of injury Potomac River Injured at work? ....

23. SIGNATURE John Redden M. D. or other 41

Address Lab rats Inc Date signed 7-15-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH *PC*

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

186a

07196

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

Charles

Marshall Corner

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

Melvin Rogers

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Negro

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1940

6. (c) If alive, give age

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 8th 1948 to July 8th 1948

and that I last saw him alive on 19

Immediate cause of death

Accidental Death

DURATION

Due to Broken Neck

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-8-48Where did injury occur? Marshall Corner Charles, Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury Fall from Tree

Injured at work?

23. SIGNATURE

M. D. or other

Address Indian Head, Md Date signed 7-8-4817. Burial or cremation (or removal) St Peter's Cemetery Date thereof July (month) (day) (year)Cemetery or crematory Marshall Corner Charles, MdLocation Marshall Corner Charles, Md18. Funeral director Brooks Funeral HomeAddress 1463 N. Carey St19. (Date rec'd by registrar) 7/10/48 ASW Healed(Date rec'd by registrar) 7/10/48 ASW HealedRegistrar Healed

9461

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8461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07197

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County CharlesCity or town Port La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifeHospital, institution, or street address where death occurred: none

How long in hospital or institution?

## 3. (a) FULL NAME

NANNIE THOMAS.

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

noo.

6.(a) Single, married, widowed, or divorced

widowed.

6.(b) Name of husband

FRANK T THOMAS

deceased

6.(c) If alive, give age years

JULY 4, 1860

7. Birth date of deceased (mo., day, yr.)

Years  
88Months  
0Days  
0It less than one day  
- hrs. min.

9. Birthplace

Port Tobacco, Chas. Co. Md.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

"

14. Maiden name

Harriet Wood

15. Birthplace

Chas. Co. Md.

16. Informant

daughter: Mary Sollers

Address

1921 Rosedale St. N.E. Wash. D.C.

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

St Ignatius

Location

Bethel Tabernacle

18. Funeral director

Harriet K. Goss

Address

Warday 2nd

19. (Date rec'd by registrar)

7/7 1948

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

CharlesCity or town Port La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No. Spring Hill

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

EST

20. DATE OF DEATH

July 3<sup>rd</sup> 1948 at 8:05 p.m.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10 July 1948 to 19 July 1948and that I last saw her alive on 20 July 1948Immediate cause of death Central vascular

accident

Due to arteriosclerosis

DURATION

3 hrs.Due to Senile degeneration13 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

none

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. W. Woodard, M.D.

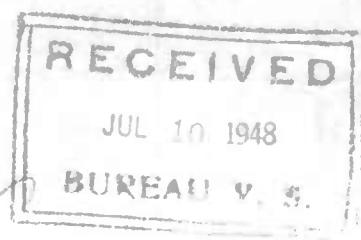
M. D. or other

Address

La Plata, Md.

Date signed

July 1948



05276  
0001  
27th  
27/1  
1948  
004

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

466

07198

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County

Charles

City or town

Benedict

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Rose O. Thompson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Cal.

Married

6. (b) Name of husband or wife

Frank Thompson

7. Birth date of deceased (mo., day, yr.)

June 10, 1886

6. (c) If alive, give age .....

years

8. AGE:

Years

Months

Days

If less than one day

62

- 26

hrs. .... min.

9. Birthplace

Charleston, W. Va.

(Town, county, and state)

10. Usual occupation

House

11. Industry or business

Harry Lee

12. Name

Harry Lee

13. Birthplace

Elgin, Ga.

14. Maiden name

Elegia Lee

15. Birthplace

El. Va.

16. Informant

Frank Thompson

Benedict, Md.

17. Burial, cremation, or removal (Which?)

Benedict

Date thereof 7-6-48  
(month) (day) (year)

Cemetery or crematory

Washington D C

Location

Melton &amp; Schley, Inc.

18. Funeral director

424 R. St. N. W. Wash D C

Address

19. 7-6 1948  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Charles

City or town

Benedict

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

EST

20. DATE OF DEATH

July 6

1948

A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on July 6, 1948 to

and that I saw her die on July 6, 1948

1948

Immediate cause of death

Carcinoma of stomach

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE... James L. Mackay, M.D.

M. D. or other

Address

La Plata, Md

Date signed 7-6-48

